Advinia Care Homes Limited

Stonedale Lodge Care Home

Inspection report

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Liverpool
Merseyside
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30 March 2023

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Stonedale Lodge Care Home is a residential care and nursing home in the Croxteth area of Liverpool, providing personal and nursing care to people aged 65 and over. The service can support up to 180 people across six units, each specialising in either residential or nursing care for older people, including those living with dementia. At the time of our inspection there were 110 people using the service.

People's experience of using this service and what we found
Governance and quality assurance systems had improved in some parts since our last inspection however they still remained ineffective. This meant people could be exposed to unsafe care. There remains a repeated failure from the provider to ensure the delivery of safe, high quality care.

People were exposed to risk of harm as some of their risk assessments and records were either not reflective of people's current needs or contained insufficient detail to help guide staff with how to support them safely. Medications were not always given in line with best practice guidance. Accident and Incident logs had improved since the last inspection; however they had not always highlighted patterns or trends.

Most of the units had been redecorated as well as some people's rooms. However, 1 person remained at risk due to a large gap in their bed between the frame and the mattress. This had not been reported or acted upon. Infection control prevention was improved, and the units looked and smelled cleaner. There were enough suitably qualified staff to support people.

People's privacy was respected. People told us they liked the staff and they felt safe at the home.

Staff liked the new manager and deputy manager and felt they had made good progress in the short time they had been at Stonedale lodge.

The manager understood their duty to share information in an open and honest manner. Safeguarding systems and policies were in place and staff could describe the action they would take if they felt people were at risk of abuse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 26 September 2022).

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of Regulations 12 and 17, however were no longer in breach of Regulation 10 and Regulation 18.

This service has been in Special Measures since 24 September 2022. During this inspection the provider demonstrated that some improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Caring and Well-led which contain those requirements. We also checked whether the Warning Notice we previously served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stonedale Lodge Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk assessments and safe care, medication administration and governance and records.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our caring findings below	**Good**
Is the service well-led? The service was not always well-led Details are in our well-led findings below	**Requires Improvement**

Stonedale Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stonedale Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stonedale Lodge Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 23 March 2023 and ended on 30 March 2023. We visited the service on 23 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 14 members of staff including the manager, the deputy manager, unit managers, senior care staff, registered nurses and care staff. We spoke with 6 people and 3 relatives about their experiences of care their loved ones received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records including 10 people's care records, multiple medication administration records, and 4 staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

After the inspection, we continued to review evidence that was sent remotely as well as seeking clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Inadequate. At this inspection the rating for this key question has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that even though some improvements were evident, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- There were risk assessments in place which described how to support people who were at risk of falling and with some aspects of their daily life, however not all risks were fully explored or mitigated. For example, 1 person who was at risk of choking, did not have remedial action documented in their risk assessment for staff to follow if they experienced a choking episode. 1 section of their care plan did not refer to their choking risk at all.
- Some people had experienced significant weight loss. 1 person for example, had lost weight and their care plan stated any weight loss should be reported to the GP or dietician. There was no information to say this had happened and the person had continued to lose weight.
- Some people had been assessed as requiring specialised diets to help them with swallowing. However, their food charts showed they were not always being given food prepared to the correct consistency, putting them at risk of choking.
- The environment had improved since out last inspection, and most of the units had been decorated. However, there was remained some broken furniture in people's rooms and an open sluice room door on one unit, where people had dementia and were walking around. This put people at risk of ingesting cleaning products. Also, one person had a large gap in their bed, between the bedrail and the bedframe, which was large enough for them to become entrapped. 1 relative told us they felt their family members room 'was a disgrace.'
- There was some incident and accident analysis in place as part of the governance arrangements at the home, however it had not always picked up when action was required.

There was no evidence anyone had been harmed; however, these examples demonstrate a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns immediately to ensure people were not exposed to risk, and the manager took

action and rectified this.

Using medicines safely
● Medication was not always being managed safely.
● As and when required medicines, often referred to as PRN were not being given in accordance with best practice guidance.
● People were regularly given PRN medications to help manage periods of emotional distress, care plans did not contain sufficient information to guide staff on what measures should be tried first to avoid overuse of medicines.
● For example, 3 people's care records stated PRN was given, sometimes more than once a day, and there was not always a clear reason recorded. 1 person was given PRN because they were 'vocal'.
● A restrictive practice audit completed in January 2023 had failed to highlight that 1 person was given PRN for emotional distress a number of times. Therefore, the potential 'overuse' of this type of medication was not highlighted or explored.

This is a breach of Regulation 12 of the Health and Social Care 2008 Regulated Activities (Regulations) 2008.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were enough suitably qualified, skilled and experienced staff to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that enough improvement had been made and the provider was no longer in breach of regulation 18.

● There were enough staff on the units to support people safely.
● Staffing levels had been increased to accommodate some 'flexi' time for unit managers to enable them to do paperwork and support the care staff.
● People we spoke with and staff told us there was enough of them and this had improved since the last inspection. Our observations on the units showed staff were present and available to support people with care tasks and to answer call bells.
● People were recruited and selected safely. References, employment history and Disclosure and Barring service checks were completed before staff started working at the home. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

During our last inspection the provider had failed to adhere to safe infection control procedures. This was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

We found during this inspection that improvements had been made and the provider was no longer in breach of regulation 12.

● Units were clean and tidy and there was enough cleaning equipment and products available to ensure a high standard of infection control was maintained.
● Areas such as people's bedrooms and bathrooms were clean and tidy.

● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding concerns were recorded and acted upon appropriately. This included referrals to relevant health and social care professionals.
● Staff had received safeguarding training and knew how to respond to incidents of concern.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

During our last inspection people's dignity and privacy was not always upheld. This was a breach of Regulation 10 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

We found during this inspection enough improvement had been made and the provider was no longer in breach of regulation 10.

- People's privacy and dignity was well respected and upheld, and we observed staff knocking on people's doors and announcing themselves before entering their rooms. One person said, "Yes they are respectful and if I want my door closed in my room, that's ok."
- People told us they felt safe and well supported by staff, and could choose how they spent their day, what they ate, and whether they had baths or showers in the morning or evening.
- People told us their laundry was always returned to them and smelt clean and fresh. Everyone we observed and spoke with looked well cared for.
- We checked linen rooms and saw there was plenty of clean bed linens and towels for people to use.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they felt the staff were kind and caring. One person said, "I can talk to the staff if I have a problem." Someone else said, "The staff are brilliant, and I can talk to any of them." Also "The staff are very kind here."
- Cultural beliefs were respected and promoted. People were supported to follow their chosen religion.
- Care plans were written in a kind, respectful and person-centred way, and people were asked which gender of staff they prefer support them with personal care, what time they liked to get up in the morning, and how many pillows they liked to sleep with.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014. This was because there was a failure to deliver adequate governance systems and repeated breaches of regulation around risk.

During this inspection, the provider had started to imbed some new process and there were some improved systems in place, however they remained overall ineffective. Therefore the provider was still in breach of regulation 17.

- There was a governance system which had started to be implemented across the home, however the new manager and deputy manager had not been in post long enough to test its effectiveness.
- Repeat changes of managers in the last few months meant that there had been some missed opportunities to complete full and concise audits, which contributed to the provider remaining in breach of Regulation 12 which we have reported on under our 'Safe' domain.
- Accident and incident processes were inconsistent. Reporting of incidents, risks, issues and concerns was not as effective as it should have been.
- There had been some positive changes in the home, such as the refurbishment of 4 of the units, and some people's rooms had been redecorated since our last inspection.
- Staffing had been increased on the units to ensure the unit managers could complete and check records, however we saw during this inspection records still required improvement, so this change had not had time to show its effectiveness.

Despite some level of improvement, governance systems, oversight and records were still not robust which put people at risk of harm. This means the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2008.

- People and staff were complimentary about the new manager and the deputy manager and knew them by name. Staff said they felt the morale was better across the units.
- The new manager and deputy manager were responsive during our inspection and took immediate and prompt action in response to some of the risks we found.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider was aware of their legal responsibility to be open and transparent when things went wrong.

● CQC had been notified of significant events which had occurred, in line with the provider's legal obligations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Regular meetings had begun to be held with people and family members to enable them to share their views about the service. We saw evidence during our inspection that feedback was listened to and acted upon by the manager.

● Staff were kept regularly informed and updated about any important changes to the service and people's needs through handovers and other meetings which took place on the units. The manager attended these to ensure they had oversight of the units.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive as and when required medication correctly. Some risk assessments were poor. There was no robust analysis of incidents and accidents, therefore missed opportunities to mitigate harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems continued to lack effectiveness. Poor management oversight meant continued breaches of regulation. Some records were poor and did not reflect peoples needs.

The enforcement action we took:

We issued a warning notice.